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Proctalgia fugax

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SYNOPSIS A personal study of 24 patients suffering from protalgia fugax is reported. It is suggested that sudden vascular congestion analogous to migraine may be the precipitating mechanism.

Proctalgia fugax has been defined as recurring attacks of distressing rectal pain with no local positive findings in the rectum. I have encountered 24 cases which were subjected to extensive study and form the basis of this report.

The ages of the patients varied between 18 and 65 years. This wide variation permitted patients to be observed in the very early stages while they had a vivid recollection of the exact mode of onset, as well as others with forty years' experience who gave a very accurate account of the course of the disease. Patients in the middle age group, on the other hand, gave a more detailed account of symptoms, principally of pain, its precipitating causes, and methods for its relief.

Descriptions of proctalgia can be traced back in the literature to Dr. Myrtle of Harrogate in 1883, and Ewing's (1953) later writings refer to this author. The actual name 'proctalgia fugax' was first used by Thaysen in 1935 (Thaysen, 1936).

INCIDENCE

Several authors join Ewing (1953) in noting the relative infrequency of proctalgia. The relatively high incidence among doctors is also stressed (Ewing, 1953).

Males suffer more commonly, with a maximal age incidence between 20 and 50 years. Many reports suggest that the trouble may first begin in early childhood (Biologist, 1952), and the disease is often familial, the father or mother and several children being affected (C.G.E., 1931; Lynch, 1931; M.C.P.F., 1935).

In my own 24 cases, 15 were men and nine were women. The disease started earlier in the men in this series: their average age of onset was 21 years (limits 18 and 26 respectively) and in women 31 years (limits 26 and 34).

The severity of attacks gradually increased in males to reach a peak at about 26 to 30 years, becoming gradually more spaced and less severe thereafter. Attacks continue in old age but become very mild. In women the disease is more prolonged so that even at 50 years of age some patients continue having severe attacks.

Only two of the patients were doctors, a young general practitioner of 26 and an older physician of 43.

Very significant is the distribution of cases in different kinds of practice as shown by the following facts:

In a general hospital (*Kasr-El-Aini* University Hospital) where the patients are of the poorer working classes only one patient with proctalgia was seen. He was a school teacher who had been operated upon for piles mistakenly supposed to be responsible for the pain. Naturally the proctalgia remained unrelieved. Otherwise I have never met the disease in the poorer working and farmer classes.

The situation was altogether different among Cairo University students presenting for treatment at the Student Hospital:

TABLE I

SURGICAL OUT-PATIENT CONSULTATIONS IN 1958-59

Total number of surgical cases		1,004
Total number of rectal cases		190
Haemorrhoids	107	
Anal fissure	30	
Anal fistula	12	
Pilonidal sinus	14	
Proctalgia fugax	8	
Abscess	5	
Proctitis	2	
Rare conditions: skin tags, polyps, P.O. stricture, etc.	12	

It is thus seen that proctalgia fugax among this class of patients accounts for 4% of all rectal cases or 0·8% of surgical complaints, outranking perianal abscess. These students are given first class medical care and present at the hospital out-patient department for very minor ailments such as boils: it is thus reasonable to assume that at their age group (16 to 26 years) proctalgia is responsible for 4% of all rectal complaints.

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All the students were males, and cases cropped up principally in April and early May just before the rigorous annual examinations. Students worried not because of pain, but because of lack of sleep and their fear that they would not be well enough to sit for their examinations. In all these patients rectal examination was negative. The average age was 21 years.

In private practice, of my own 1,024 rectal cases (1949-59) proctalgia was encountered only five times, *i.e.*, an incidence of 0·5%, eight times less commonly than among university students. The average age for all the private rectal cases was 33 years. In contrast to the university students private patients with proctalgia did not seek advice unless they were complaining of an organic or tangible condition in the anus, *e.g.*, bleeding per rectum or second degree piles. Yet there is no reason to believe that proctalgia is less common among these patients than among students. It is possible that students seek advice earlier because they worry that they may be incapacitated at the time of examinations. Especially is this the case since the students are experiencing the attacks for the first time and have as yet not got accustomed to them, nor can they foretell their ultimate course.

It is indeed probable that proctalgia is commoner than one is led to suspect, as was spectacularly demonstrated by my accidentally discovering 10 patients who had never complained. At a party a close friend of my own was suddenly taken ill and retired to an adjacent bedroom, where he proceeded to take off his shoe, fold his leg under him in a chair, and sit with his heel tightly pressed against the anus. He explained this extraordinary behaviour by the fact that since the age of 22 he had been subject to recurring attacks of severe rectal pain, and had been taught to relieve the pain in this manner by his mother who herself suffered from proctalgia. In turn the mother had received the advice from a grandmother, and closer questioning revealed that 10 members of the family suffered from proctalgia. None of these patients had sought medical advice in spite of being wealthy, well educated, and accustomed to seek advice for the most trivial of complaints. Similar families must exist and remain unknown to physicians or statisticians.

MODE OF ONSET

In its commonest form the disease starts with nocturnal attacks of pain. Other ways of onset are less common and the patients ultimately develop the nocturnal attacks. In a typical case (No. 20 of this series) pain is first felt in the rectum late at night or awakens the patient from sleep. The pain is not particularly severe, the patient falls asleep, and next morning the attack is forgotten. A month later a severe attack occurs and is repeated for four or five times. The next severe attack awakens the patient from sleep and this time the severe rectal pain is accompanied by a lower abdominal cramp-like pain. The patient usually feels sick, perspires freely, and syncope is marked. The attack lasts 10 to 15 minutes and ends by the passage of flatus and the patient falling asleep.

Less frequently (two cases) the pain first comes while straining at stool and is repeated at intervals of two to three weeks, then it is succeeded by severe pain on defaecation associated with syncope. The patient may be forced to lie prostrate on the floor until the attack passes. Sooner or later typical nocturnal attacks develop. The patients, however, always remain subject to attacks during defaecation. Pain never follows an easy, massive evacuation, in which the whole left colon participates, but always follows straining to empty the rectum. On occasion typical attacks follow the use of a glycerine suppository.

A third uncommon occurrence (two cases) is an onset associated with diarrhoea. With a recurrence of diarrhoea, even months later, the patient gets a severe prostrating attack of proctalgia, to be followed by typical nocturnal attacks. Such patients have a great fear of diarrhoea because it may be followed in 24 to 48 hours by a diurnal and more than one nocturnal attack.

Patients who start off with typical nocturnal attacks may later develop attacks following defaecation or spontaneously in the daytime. Also people used to sleeping in the afternoon may develop serious attacks during their siesta.

CLINICAL FEATURES

Like epilepsy attacks of proctalgia may be classified into attacks of 'petit mal' and 'grand mal'. The severe attack has a definite aura, while the mild one does not. Typically they occur between 4 and 5 a.m.; on rare occasions more than one attack occurs in the same night. During periods of anxiety or fatigue attacks may occur on several consecutive nights. An average interval of about one month between attacks is common.

The severe attacks of 'grand mal' have an aura which is localized to the lower abdomen and is of a vague nature difficult to describe. The patient becomes aware that the pain will occur about half a minute before the attack, and may wake up from sleep before any pain. The pain itself is deep seated or high in the rectum, severe and agonizing, lasts

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10 to 15 minutes and is accompanied by marked syncope. On the rare occasions where rectal examination was possible during a severe attack, I noticed that the sphincters were relaxed or patulous. There was no evidence of spasm in the rectum as far as the finger could reach.

The mild attack 'petit mal', is felt lower down in the rectum, lasts much longer (20 to 90 minutes), is never accompanied by syncope, and clinical examination during the attack showed the sphincters to be spasmodic on several occasions.

The patients are more worried about the syncope than the pain. They keep beside their beds more stimulants than sedatives. Such remedies as brandy, ephedrin, cardiazole-ephedrin, coramine drops, smelling salts, and eau de cologne are found at the bedside of patients more usually than supposedol and spasmocibalgine suppositories, for example.

Some of them are so frightened that they carry medications with them to the lavatory and even keep them in their pockets in case they develop the pain outside their homes.

At the start of the disease attacks are invariably of the petit mal type, but soon pass to the severe type. As the patients get older they once more revert to the milder variety and attacks become more widely spaced. Once in a while an attack of milder character may end as a severe attack. Rarely syncope precedes the pain.

At the height of an attack there is an intense desire to empty the rectum. Attempts to do so are very painful and even if successful fail to relieve the attack. Passage of flatus invariably follows the severe but not the mild attacks.

The association of priapism or erotic dreams is reported by several authors but were not encountered in this series. On a few occasions severe attacks developed in my patients during or at the beginning of coitus. Erection immediately disappeared. Priapism frequently follows severe attacks and sexual desire is intense. Coitus following severe attacks is reported as being very satisfying.

Exciting causes that precipitate attacks are very variable and may be related to work, mental condition, physical or sexual factors. A change of climate has affected several of my patients favourably while they were on vacation. Local inflammation (colitis) in the colon may be a definite exciting factor as may certain foods or drugs that induce loose bowel motions; of special mention in this category are broad-spectrum antibiotics, sulpha drugs, serpasil, shrimps, eggs, and chocolate.

In the diagnosis of proctalgia one should avoid incriminating coexisting local anal lesions, and should not confuse the rectal crises of tables and of anal fissures.

AETIOLOGY

Several authors join Ewing (1953) in postulating a psychoneurotic or nervous origin for the disease. It is a more frequent occurrence in the sophisticated and higher social grade of patients, and the commoner incidence of attacks under conditions of stress, anxiety, or preoccupation, do indeed corroborate this view. Others link the origin with various causes, such as erythromelalgia, scybalous impaction, or even some kind of epilepsy.

I, however, discovered in Bolen's (1943) sigmoidoscopic findings, quoted by Ewing, during an attack of proctalgia a possible clue to the aetiology. Bolen's report is unique in the literature; sigmoidoscopy in a man aged 60 during an attack revealed a reddened, swollen mucosa with prominent vessels. Pressure with the tip of the instrument at the central point of the levator caused mild spasm. Difficulty was encountered in negotiating the recto-sigmoid and gas escaped as soon as the corner had been turned. That the attacks evoke this triad of swollen mucosa, prominent vessels, and obstruction at the recto-sigmoid recalls the episodic vascular attacks involving the superficial temporal artery in cases of migraine. Moreover it may be noted that attacks of migraine are precipitated or aggravated by factors somewhat similar to those that are associated with proctalgia.

In the present series the patient with the peculiar family incidence involving 10 members of his family has already been referred to. One of the sufferers had migraine. It is possible to envisage a train of events explaining severe attacks of proctalgia. To start with vessels at the rectosigmoid junction may suddenly become dilated, to be followed by congestive swelling of the overlying mucosa, which, propelled by the peristaltic wave, may become prolapsed down the rectum for some distance. At this stage sigmoidoscopic findings will correspond to the findings described by Bolen. Localization of primary changes in this area explain both high rectal and lower abdominal or pelvic pains seen in severe attacks. The escape of gas at the end of the attack would follow spontaneous reduction of the oedematous mucosa. Strong support for this hypothesis is lent by the relief that many patients experience on adopting a posture which raises the sigmoid into the abdomen and away from the rectum. Thus many are relieved by adopting the 'genu-pectoral position', and at times attacks may be aborted or serious ones transformed to a mild variety by adopting this posture during the 'aura' phase. Likewise firm pressure directed upwards from the anal region, as previously described, tends to push the anus and rectal contents upwards and bring about relief of pain.

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Again mild attacks, which I believe occur lower in the rectum, are accompanied by contraction of the sphincters, as to be expected with any painful stimulus in this area. With the severe attacks mucosal prolapse at the recto-sigmoid induces the intense desire to defaecate with the natural response of relaxed sphincters.

The autonomic nervous system is also undoubtedly involved in proctalgia, as the syncope that accompanies severe attacks is entirely out of proportion to the pain.

TREATMENT

The real difficulty in treating proctalgia lies in preventing attacks. This is practically impossible, and all efforts directed towards this end have failed so far.

Amyl nitrite is reported to bring immediate relief. However it has little or no effect on the 'petit mal' type of crisis. If anything it may be effective in severe cases, attacks of which are in any case, so short lived that relief can hardly in my opinion, be attributed to these drugs.

Gabriel (1948) advises neurotrasentine, or phenobarbitone for highly nervous individuals requiring continuous treatment. Many of our patients are almost neurotrasentine addicts, and many have been taking barbiturates for years with no significant effect on the attacks.

The use of suppositories containing different sedatives and antispasmodics is advocated by some authors. They seem to have little effect. The use of antihistaminic drugs is equally futile. Antimigrainous drugs here not tried because this idea occurred to me only recently, and the drug should prove itself of value against migraine first.

Many patients at the beginning of the attack take stimulants such as coramine, or sedatives such as aspirin or novalgin or both, but the attack is naturally relieved before either has time to act. In mild cases, stimulants are not needed, and sedatives have some effect.

There are many other ways, such as the application of heat to the anus, taking a hot or a cold drink or some food.

In my opinion, the best way to deal with the condition is to reassure the patient of the absence of any serious organic rectal lesion. To bring about as much mental and physical relaxation as possible postural treatment is the most effective. Once the attack is impending, the genu-pectoral position can be adopted, or better still, the patient is advised to lie down on the right side with the buttocks slightly elevated on a pillow, and this should be supplemented by firm pressure on the anus using the left hand for that purpose. This may abort or greatly alleviate a severe attack.

It is evident that the patient should avoid the kind of food or drug that, in his experience, precipitates the pain.

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